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An Occupational Therapy Guide for Improving Social Performance in Adolescents within the Juvenile Justice System

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An Occupational Therapy Guide for Improving Social Performance in Adolescents Within the Juvenile Justice System

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TABLE OF CONTENTS

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ABSTRACT

An Occupational Therapy Guide for Improving Social Performance for Adolescents Within the Juvenile Justice System. Missy Law, Ashle Hicks and Sonia Zimmerman, Department of Occupational Therapy, University of North Dakota School of Medicine & Health Sciences, 501 North Columbia Road, Grand Forks, ND 58202.

Occupational therapists believe social participation is an important aspect of adolescent development. Social participation problems can be linked to mental health diagnoses and delinquency. Adolescents who are court ordered into the juvenile justice system often do not receive the necessary treatment due to lack of resources within the community.

A comprehensive literature review was conducted to gather information regarding social participation aspects in relation to adolescent delinquency and placement within the juvenile justice system. The findings suggest there is more emphasis placed on punishment for adolescents rather than rehabilitation. Interventions used to support rehabilitation are primarily limited to counseling. A need exists for expansion of a handbook titled "Building Bridges", which was developed to present the role of the occupational therapist in addressing the social participation concerns of adolescents in the juvenile justice system.

The goal of this project is to increase awareness of the persistent problems with juvenile delinquency, and to enhance the knowledge and confidence of occupational therapists working with this often challenging population. Occupational therapy services

have the potential to assist in the development of adolescent social competence and improve performance of daily occupations.

CHAPTER I

INTRODUCTION

Adolescence is a unique transitioning period characterized by many physical, emotional, and social changes. At this stage, much emphasis is placed on social interaction, which plays a critical role in the youth's physical, emotional, and cognitive development, especially in forming a sense of identity, establishing relationships, and maintaining psychological well-being. For some youth, these changes in the developmental process can pose challenges marked by social difficulties with peer and family relationships intertwined with negative emotions and behaviors that may lead to delinquency.

Frequently, these psychosocial problems go undetected and/or untreated, due to limited access to mental health services and/or a lack of financial resources. As a result, many adolescents are placed within the juvenile justice system with greater emphasis on punishment rather than rehabilitation. Not only is this costly for society, this hindered environment is a barrier for social performance, due in part to a lack of opportunity for developing and learning the skills necessary to participate in or seek out social situations, build close relationships with others, or interact appropriately within society.

Occupational therapy (OT) places much value on social participation as a necessary component for healthy living (AOTA, 2002). In addition to poor social performance, impairments in social participation can significantly influence functioning in other areas of an individual's life, including self-care, work, education, and/or participation in leisure activities. In adolescence, social impairment can lead to poor academic performance, loss of motivation for future aspirations or employment, and lack of close relationships, which may contribute to isolation and depression. Because social interaction is so vital at this stage of development and highly valued by occupational therapy, this project proposes to meet the need for OT-based intervention that particularly targets social participation as the performance area of concern for those youth who are in the juvenile justice system. A handbook is presented for use by occupational therapists employed in mental health facilities that provide intervention to adolescents. The handbook serves as a guide and resource for intervention planning and implementation, and includes diagnostic information, strategies for building rapport with high-risk adolescents, assessment options, a sample program, and references. It also provides a more comprehensive view of the Model of Human Occupation (MOHO) and how it may be applied in practice. MOHO was selected for use in this project because of the extensive research backing its applicability and effectiveness for the adolescent population, as well as mental health concerns and delinquency. MOHO is occupation-based and client-centered, and is compatible with other practice models.

Definitions

Youth: For this project, youth is referring to the period of adolescence or an individual within this stage between the ages of 10 and 17.

Juvenile Justice System: The juvenile justice system is a legal system for those who have not yet reached adulthood and have been court-ordered into a detention facility, treatment or mental health center, or rehabilitative program. Within the justice system, the age at which a person is considered a juvenile or an adult is determined by the laws in each state.

This scholarly project and implementation of the handbook is intended to serve several purposes, including expanding the knowledge and confidence of therapists working with this difficult population. It is hoped that this project will help bridge the gap in services for adolescents within the juvenile justice system and promote advocacy for improving social aspects of adolescent care.

Chapter II consists of a comprehensive literature review addressing the social characteristics of adolescence, and those aspects of social interaction in relation to emotional-behavioral concerns and delinquency. The methodology utilized throughout this project is described in greater detail in Chapter III, and the finished handbook is presented in Chapter IV. Chapter V consists of a summary of the scholarly project, including limitations and recommendations for further development of the project. The scholarly project concludes with a full listing of the references used throughout.

CHAPTER II

LITERATURE REVIEW

Introduction

Adolescents face a variety of challenges in the transition from child to young adult. For some, social difficulties with peer and family relationships interconnected with negative emotions and behaviors are frequently experienced. Persistent social and behavioral issues often result with involvement in the juvenile justice system. A variety of disciplines addressing social issues as an area of concern are referred to in the current literature, however, occupational therapy services are rarely mentioned. Since occupational therapy values social participation as a necessary and key component for healthy functioning (AOTA, 2002) a need to incorporate occupational therapy treatment strategies designed to address social issues in adolescents who experience emotional and behavioral problems is present.

The American Occupational Therapy Association (AOTA, 2002) defines social participation as "activities associated with organized patterns of behavior that are characteristic and expected of an individual or an individual interacting with others within a given social system" (p. 621). These activities encompass the individual's successful interactions within a variety of social contexts, including those at the community level (i.e. neighborhood, work, school, etc.) and within one's specific roles

(i.e. family member, student, peer, etc.), that ultimately affect health and well-being (2002).

Human Development

Human development not only involves the physical and biological process of maturation, but it also involves one's ability to adapt to change. In Cole (2005), theorists such as Erikson and Kohlberg acknowledge the importance of social interaction in human development, with emphasis on social relationships and adaptations that individuals must make throughout all stages of the lifespan in response to social conflict, moral dilemma, acquired skills, environmental impact, and role changes. Within the developmental cycle, social interaction begins as early as infancy with the bonding experience between parent and infant, which is considered detrimental to the physical and emotional growth of the child, and sets the stage for future social interaction. As children further develop, they use social activities to form a sense of identity, and they begin to build relationships with those outside of the family structure. According to Santrock (2003), social relationships with others are closely linked with a child's cognitive, emotional, and moral development. This indicates that social participation can have an impact on thought processes, the ability to cope, and behavioral choice based on distinction between right and wrong. Han & Kemple (2006) suggest that the earlier children develop social competency, which includes self-regulation, interpersonal skills, positive self-identity, cultural awareness, social values, and planning/decision making skills, the more likely they are to be successful in their social interactions as adolescents and adults.

Parental Influence

Social behavior is often dependent upon the situation in which it occurs, therefore adolescents are easily influenced by societal pressures and the demands from those who have the most contact with them. Parents and caregivers may be the largest contributor to adolescents' social well-being or lack of, due to their role throughout the development process in shaping the child's self-concept through teaching values and role modeling appropriate behaviors. The level of parental involvement and support is frequently linked to youths' outward demonstration of behaviors and the ability of the adolescent to cope with external stressors. For example, Elliot et al. (2005) discovered that youth who are raised in stressful or abusive home environments often have difficulty coping because they perceive themselves as victims, resulting in social isolation, detached relationships, poor social competency, and decreased self-esteem. According to Hall-Lande et al. (2007), a strong family support with a sense of close connectedness has been shown to be a protective factor against social isolation and negative risk-taking behaviors such as drug use, violence, and suicidal ideation.

Peer Influence

Since school is a primary context for adolescents, relationships with peers also play a major role in influencing adolescent behavior. Peers often serve as a primary support system, especially if there is little parental involvement in the home. A supportive environment is a key component of strong social influences and assists with buffering the impact of stressful situations. Youth who lack much needed support often turn to negative ways of receiving it, such as joining a gang. According to the National Report of Juvenile Offenders and Victims, (Snyder & Sickmund, 2006) more than half of

the youth in a local gang reported that they joined because of pressure by peers and a feeling of support and belonging.

In contrast, many adolescents choose to avoid interaction with peers altogether, which can result in social isolation and depression. Social isolation occurs when an individual chooses not to participate in activities that include others, and it may lead to suicidal ideation. Elliot et al. (2005) identify multiple factors that may inhibit social interaction, including gender, ethnicity, socioeconomics, geographical location, and exposure to abusive situations, which often influence an adolescent's decision to socially isolate. Difficulties relating to peers may be another factor, particularly if the adolescent is victimized or perceived as "different" (Hoglund & Leadbeater, 2007). For example, Macdonald, Sauer, Howie, & Albiston (2005) found that many who felt different from others as a result of psychosis, voiced an increased need in all levels of social support, however, many of them chose to isolate themselves due to uncertainty of how to initiate or maintain social relationships with peers. This shows evidence that peer reactions may play a huge role in adolescent behaviors and the level of social participation. According to Kelly, Jorm & Rodgers (2006), adolescents, and more frequently males, often have difficulty knowing how to appropriately react to peers who are perceived as different, especially those who display emotional and/or behavioral distress. In a study of peer support (2006), twenty-four percent of the adolescents implied they could offer support to a friend by providing illegal drugs and alcoholic beverages, and one in five indicated they would offer no support at all. Similarly, many adolescents are both victims and perpetrators of abuse and bullying by peers, so it is of no surprise that many choose to keep to themselves.

Mental Health

For many adolescents, social difficulties with peer and family relationships are interconnected with negative emotions and behaviors that are linked to larger mental health concerns. According to Johnson et al. (2000), adolescents are frequently affected by a number of psychosocial diagnoses, including attention deficit hyperactivity disorder (ADHD), depression, anti-social disorder, conduct disorders, posttraumatic stress disorder (PTSD), anxiety disorders, and personality disorders. With these disorders, adolescents may exhibit a number of negative behaviors that include, but are not limited to, hyperactivity, extreme sadness, aggression, panic, and impaired social relationships. Johnson et al. (2000) found that those who are diagnosed with narcissistic, histrionic, paranoid, borderline, and passive-aggressive personality disorders are more likely to commit violent acts, such as threats to injure others, physical fights, arson, vandalism, breaking and entering, and robbery or assault.

Psychosocial disorders such as these are a common risk factor influencing the development of delinquent behavior, especially when adolescents experience comorbidity, or multiple diagnoses. Persistent social and behavioral issues often manifest in the school environment, where punishment begins with detention and expulsion from school. Atkins et al. (1999) express that because communities often lack the resources to diagnose and treat adolescents with mental/emotional disorders, more youth are being transitioned into the juvenile justice system rather than receiving the appropriate mental health services they need.

Juvenile Justice System

The juvenile justice system is often comprised of a number of community-based facilities, such as youth crisis centers, residential group homes, juvenile detention centers, and hospital/community mental health centers. Snyder & Sickmund (2006) report that in 2003, more than 2.2 million arrests were made involving adolescent offenders between the ages of 10-17. Of those arrests in 2003, 62% of the adolescents were ordered into public facilities that include state and local entities such as detention centers, long-term security facilities, state honor farms, or training schools, while only 38% of adjudicated adolescents were sent to private institutions such as group/residential homes, shelters, or boot camps. In addition, a nationwide census showed that in 2002, facility crowding was already becoming a problem, with nearly 40% of all public facilities at or over their standard bed capacity. Some were even forced to create makeshift accommodations. The cost of meeting the demand of juvenile incarceration weighs heavily on society. According to Feld (2001), juvenile justice agencies in the United States spent between $10 and $15 billion in 2000 to "prosecute, supervise, punish, and treat adolescents accused or convicted of delinquent or criminal behavior or to prevent adolescent crimes before they occur" (p. 8).

According to the National Report on Juvenile Offenders and Victims (Snyder & Sickmund, 2006), society in the 1980's viewed the juvenile justice system as too lenient, therefore, treatment was shifted from a rehabilitative perspective to one that focused more on punishment. This resulted in more juveniles being placed in adult facilities, putting them at higher risk for abuse, assault, violence, and repeated offenses (www.aclu.org/crimjustice/juv/10091res19960705.html). Snyder & Sickmund (2006)

reported that the number of adolescents held in adult jails increased more than 300% between 1990 and 1999, but has since then decreased due to the passing of the Juvenile Justice and Delinquency Prevention Act, which limits the placement of juveniles in adult facilities.

In spite of the segregation between adult and adolescent offenders, adolescent facilities still continue to face issues with overcrowding, along with a narrowed focus for providing treatment. Many facilities, especially those at the state and local level, may still embrace the belief in a punitive over rehabilitative approach and/ or lack the resources to offer more diversified intervention. Arredondo (2003) suggests that using a punitive rather than a rehabilitative approach is not beneficial for an adolescent population and could actually increase the prevalence of criminal behaviors in later adulthood. He argues that adolescents are especially impressionable and because they are in a different developmental stage than adults, they do not emotionally and socially respond to punitive actions in the same way that an adult might. Therefore, the impact of treating adolescents as adults could be detrimental to their continuing developmental process and result in the creation of maladaptive behaviors. Arredondo (2003) indicates the need to deviate from "punishing, controlling, and deterring behavior" (p. 4) and move more toward a rehabilitation focus where the goal is to "foster positive social development (healthy personal, social, and moral maturation) of youth" (p. 4). It is possible that professionals working within the juvenile justice system or other mental health facilities choose to treat youth as adults because they do not fully understand the complexity of an adolescent's unique developmental process or the multiple factors that contribute to their behavior. Literature suggests that more in-depth research is needed for developing diverse

interventions that are useful for treating the adolescent population (Granello & Hanna, 2003; Bonham, 2006; Gol, 2005; and Hanna, Hanna, & Keys, 1999).

Treatment

One of the most common forms of treatment is individual counseling by a psychologist, social worker, or case manager. This method of treatment is especially useful for those who exhibit defiant, violent, or aggressive behaviors that may be linked to environmental factors, social stressors, and /or abuse/trauma (Granello & Hanna, 2003; Hanna, Hanna, & Keys, 1999). Multiple treatment strategies have been identified in the literature for creating a positive client/therapist relationship with adolescents who exhibit these behaviors (Hanna, Hanna, & Keys, 1999). In addition, King et al. (2006) suggest that counseling via the internet is becoming a common form of treatment used by adolescents, and adolescents reported using this non-interpersonal method of help seeking because it made them feel safer and less vulnerable than face-to-face interaction.

Another treatment strategy that is commonly used involves social skills training through a cognitive behavioral approach. The purpose of this approach is to change adolescents' negative thinking patterns that ultimately affect their behaviors (Bruce & Borg, 2002). According to Sim et al. (2006) and Han & Kemple (2006), the goal of social skills training is to teach aspects of social competency that will improve the individuals' interpersonal relationships, build confidence in addressing social situations, and offer more self-control. Although there is some discrepancy about the long-term efficacy with using social skills training, it has shown some effectiveness especially when implemented early in childhood. When treating adolescents, especially those with emotional and behavioral concerns, Magg (2005) suggests using an approach in conjunction with social

skills training that focuses to find a positive alternative as a replacement for the negative behavior, rather than suggesting the adolescent just cease the behavior. Research indicates that learning social skills related to interpersonal relationships and putting those into practice can have a positive influence on an individual's involvement in other daily living activities, such as self-care and the ability to manage one's environment (Gol & Jarus, 2005).

When treating adolescents, it is also important to consider gender differences. Snyder & Sickmund (2006) report that although there has been an overall decrease in criminal behavior among juveniles, offenses by females is continuously on the rise. According to Calhoun, Bartolomucci, & McLean (2005), relational difficulties have a greater affect on females in comparison to males because of the heavy emphasis females put on the value of relationships in assuming their identity and connecting to others. When treating female adolescents, Steese et al. (2006) and Calhoun, Bartolomucci, and McLean (2005) recommend using a relational group with emphasis on a supportive environment for increasing meaningful relationships, "self-esteem, self-efficacy, body-image, and locus of control" (p. 63).

Role of Occupational Therapists

According to Snively & Dressler (2005), the blending of mental health and the criminal justice system has created a need for occupational therapy to be involved as part of the interdisciplinary team that works within the justice system, including: nursing, psychiatry, psychology, counselors, social work, and case management in order to provide the most effective treatment. Occupational therapy's role involves administration and consultation that includes evaluations, group/individual treatments,

program development, and case management. The focus is to ensure safety, conduct performance evaluations, and provide interventions that can be graded to achieve the individuals' goals. The occupational therapist "facilitates skill development in order to help patients function at their maximum potential within their current institutional environment and be more productive and successful when they reintegrate into the community." (2005, p.569). Treatment frequently includes but is not limited to: self-care, interpersonal skills, coping skills, independent living skills, stress management, problem-solving strategies, and vocation training. Occupational therapists also assist with discharge planning and providing services and support for the patient within the community.

Therapists often develop and incorporate community programs into treatment since this is a vital component of the adolescent context. Scaletti (1999) suggests the importance of facilitating community development as a means of providing opportunity and empowering patients diagnosed with a mental health disorder to take responsibility for their own health by developing systems of mutual support, participating in community activities, and building social connections with those who have similar interests.

Occupational therapists also implement leisure activities as another component that affects mental health. Passmore (2003) and Passmore & French (2003) indicate that leisure is an important occupation that "supports health through the development of a range of competencies including social, behavioral, athletic, and scholastic competencies" (Passmore 2003, p. 81). In addition, results found that leisure activities which focused on personal accomplishment and those which involved interaction with

others were the most beneficial in terms of positively influencing mental health. Leisure activities can encompass a wide variety of tasks, however, a common theme that many adolescents, in a study by Passmore & French (2003) identified, is that leisure must be enjoyable for the individual and provide him/her a sense of control by allowing the individual to make decisions about the activities they partake in. Regardless of intervention provided, Bouteloup & Beltran (2007) indicate the importance of using theory to guide occupational therapy practice for adolescents.

Model of Human Occupation

Occupational therapy utilizes theoretical constructs to connect the philosophy of human occupation to practical application through use of evidence-based and client-centered intervention. One of the most commonly implemented theories used by occupational therapists is the Model of Human Occupation (MOHO). This model was developed in the 1980's by Gary Kielhofner in response to occupational therapy's contemporary paradigm shift with emphasis on occupation as the primary philosophy (Kramer, Hinojosa, & Royeen, 2003).

Kielhofner created this model as a guide for conceptualizing clients' occupational functioning, to be implemented with persons experiencing various impairments and it can be used throughout any stage of development, making it an appropriate theory for the adolescent population. Extensive research has been conducted on the use of this model for assessing and treating adolescents with mental health concerns and delinquency. According to Munoz, Lawlor, & Kielhofner (1993) therapists in mental health who have used this model have expressed that MOHO most closely matches the occupation-based philosophy of OT through a holistic, comprehensive, and organized approach.

The foundational principles of MOHO are centered around the idea that "human beings having an innate desire to explore and master their environment by engaging in occupational behavior" (Sholle-Martin, 1987, p. 4) Concepts of this model focus on a systems approach where behaviors of the person are assessed in regard to volition (personal causation, values, and interests), habituation (habits, roles, and routines) and performance capacity (personal experience and skill), in addition to the impact of the physical and social environment in which occupation occurs.

As adolescents transition from childhood, they experience a significant change in their values, interests, habits, roles, and skills, which is especially true for those who are delinquent and in the juvenile justice system. Lederer, Kielhofner, & Watts (1985) suggest that delinquent adolescents are not immoral individuals, but rather they deviate from typical social roles because they find meaning and value in different behaviors. For example, in this study delinquent adolescents placed less value on the roles of student, worker, volunteer, homemaker, and caregiver than the non-delinquent adolescents, therefore, leading them to participate in "solitary or deviant roles" (p. 74). Interests of adolescents frequently change, dependent upon developmental stage, peer influence, and the roles that they place value on, and leisure activities often replace more productive behaviors. Juveniles within the juvenile justice system may also demonstrate deficits in occupational functioning due to a lack of motor, process, and communication/interaction skills necessary for them to succeed academically, vocationally, and socially.

The final concept of the MOHO model emphasizes the impact of the environment, particularly the interaction between the person and the physical and social contexts. Environmental aspects should be carefully considered when assessing an

individual's engagement in occupations, as it could either provide an opportunity or barrier to participation. Adolescents in the juvenile justice system experience some barriers evidenced in their negative home environments, such as distrust, avoidance between family members, lack of feelings of belonging, and lack of communication. In order for the occupational therapist to clearly understand the client's occupational performance, all environments should be considered (i.e. work, school, home, and social activities), especially since those in the juvenile justice system may experience difficulty in all of these areas.

The MOHO model offers a variety of assessments used with adolescents and formal strategies for developing interventions and specific programs. The overall goal of using this model is to facilitate clinical reasoning by the therapist in developing intervention planning and implementation that will serve to elicit and enable behavioral change in the adolescents.

The focus of this project is to provide knowledge and information that may be useful to bridge the gap in services between the juvenile justice system and successful integration into the community. It is hoped that by educating occupational therapists, it will increase advocacy and reduce apprehension when treating adolescents. This knowledge and advocacy could expand much needed mental health services that are often lacking.

In titles Building Bridges, the project is a reference tool for use by occupational therapists employed in mental health facilities. This could also be implemented into a variety of settings, including: youth crisis centers, juvenile detention centers, group homes, and other community mental health centers. The Building Bridges handbook will

serve as a guide to provide a better understanding of mental health deficits and disorders that effect social participation; provide possible assessments that may be used to evaluate youth; provide possible treatment strategies and sample interventions that may be used for program development; and resources that therapists can access for further information.

CHAPTER III

METHOD

An extensive review of literature was conducted by first searching multiple online databases, including CINAHL, PubMed, and OT Search, in addition to using occupational therapy textbooks and obtaining current factual information through the internet. The purpose of this search was to gather information regarding the social features of adolescence, and more specifically, social aspects in relation to adolescent delinquency and placement within the juvenile justice system. The process involved research of various topics including adolescent rehabilitation, socialization in youth, and juvenile justice statistics. Specific themes were developed based on consistency in the literature findings, which included the role of social interaction in human development, the influence of peer and family relationships, and the impact of mental health on social functioning. The literature also provided statistical information about juvenile crime and identified the intervention methods typically employed when treating adolescents.

Research revealed the need for expanding rehabilitation services for juvenile delinquents and the valuable role of occupational therapy in providing those services. Multiple occupational therapy theories and models were evaluated to determine the degree of relevance for treating this population. Based on extensive evidence of its use and applicability for troubled youth, the Model of Human Occupation (MOHO) was

selected for use as a resource in creating a handbook, titled Building Bridges, that may be utilized by occupational therapists when treating adolescents within the juvenile justice system. Information in the Building Bridges handbook was derived from the literature and emphasizes social participation as the primary focus. The concepts of MOHO were analyzed and assisted in the selection of pertinent assessments for inclusion, along with information on common psychosocial diagnoses, treatment strategies that encompass social interaction, and a sample program that may be implemented into any mental health facility.

The goal of this project is to increase awareness of the persistent problems with juvenile delinquency, and to enhance the knowledge and confidence of therapists working with this difficult population. It is believed that by bridging the gap in services for adolescents within the juvenile justice system, repeated offenses may occur less often, the burden to society may be alleviated, and delinquent youth may become more socially competent and productive in their daily occupations.

Building Bridges
An Occupational Therapy Guide For Improving Social Performance In Adolescents Within The Juvenile Justice System

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TABLE OF CONTENTS

Introduction

Adolescents face a variety of challenges in the transition from child to young adult. For some, social difficulties with peer and family relationships interconnected with negative emotions and behaviors are frequently experienced. Persistent social and behavioral problems can often result in severe impairment and eventual involvement in the juvenile justice system. A variety of disciplines address negative social issues as an area of concern, however, occupational therapy services are frequently underutilized. Since occupational therapy values the importance of social participation as a necessary and key component for healthy functioning (AOTA, 2002), there is an increased need to integrate occupational therapy services within the rehabilitative approach, with treatment strategies designed to address social issues among adolescents who experience emotional and behavioral problems.

This handbook serves as a resource for occupational therapists working with adolescents within the juvenile justice system who are employed within a variety of mental health facilities. It provides the occupational therapist resources for intervention planning and implementation based on a client-centered approach using the Model of Human Occupation (MOHO). The handbook focuses specifically on social participation and contains the following: an overview and rationale for use of the MOHO model; descriptions of mental health disorders commonly observed in adolescent offenders; assessment options specific to the model, along with access information; strategies for building rapport with troubled youth; and a social wellness program that outlines the application and use of MOHO concepts in regard to identifying client challenges and

needs, and developing treatment strategies that target the adolescents' social deficits. This handbook strives to: (1) increase awareness of the social concerns in juvenile delinquency; (2) enhance the knowledge and confidence of occupational therapists working with troubled adolescents; (3) provide information that is user-friendly and easily accessible; and (4) strengthen the occupational therapy profession by using evidence-based literature to guide practice.

Model of Human Occupation

Occupational therapy utilizes theoretical constructs to connect the philosophy of human occupation to practical application through use of evidence-based and client-centered intervention. The Model of Human Occupation was developed in the 1980's by Gary Kielhofner in response to occupational therapy's contemporary paradigm shift with emphasis on occupation as the primary philosophy (Kramer, Hinojosa, & Royeen, 2003).

Kielhofner created this model as a guide for conceptualizing clients' occupational functioning and developing strategies for interventions. MOHO may be implemented for use with persons experiencing various impairments and throughout any stage of development, making it an appropriate theory for the adolescent population. Extensive research has been conducted on the use of this model for assessing and treating adolescents with mental health concerns and delinquency. According to Munoz, Lawlor, & Kielhofner (1993) therapists in mental health who have used this model have expressed that MOHO most closely matches the occupation-based philosophy of OT through a holistic, comprehensive, and organized approach.

The foundational principles of MOHO are centered around the idea that "human beings having an innate desire to explore and master their environment by engaging in occupational behavior" (Sholle-Martin, 1987, p. 4) Concepts of this model focus on a client-centered approach where behaviors of the person are assessed in regard to volition (personal causation, values, and interests), habituation (habits, roles, and routines) and performance capacity (personal experience and skill), in addition to the impact of the physical and social environment in which occupation occurs.

As adolescents transition from childhood, they experience a significant change in their values, interests, habits, roles, and skills, which is especially true for those who are delinquent and in the juvenile justice system. Lederer, Kielhofner, & Watts (1985) suggest that delinquent adolescents are not immoral individuals, but rather they deviate from typical social roles because they find meaning and value in different behaviors. For example, Lederer, Kielhofner, & Watts (1985) found that delinquent adolescents placed less value on the roles of student, worker, volunteer, homemaker, and caregiver than the non-delinquent adolescents, therefore, leading them to participate in "solitary or deviant roles" (p. 74). Interests of adolescents frequently change, dependent upon developmental stage, peer influence, and the roles that they place value on, and leisure activities often replace more productive behaviors. Juveniles within the juvenile justice system may also demonstrate deficits in occupational functioning due to a lack of motor, process, and communication/interaction skills necessary for them to succeed academically, vocationally, and socially.

The final concept of the MOHO model emphasizes the impact of the environment, particularly the interaction between the person and the physical and social contexts. Environmental aspects need to be carefully considered when assessing an individual's engagement in occupations, as it could either provide an opportunity or barrier to participation. Adolescents in the juvenile justice system experience barriers evidenced in their negative home environments, such as distrust, avoidance between family members, lack of feelings of belonging, and lack of communication. In order for the occupational therapist to clearly understand the client's occupational performance, all environments need to be considered (i.e. work, school, home, and social activities),

especially since those in the juvenile justice system may experience difficulty in all of these areas.

The MOHO model offers a variety of assessments used with adolescents and formal strategies for developing interventions and specific programs. The overall goal of using this model is to facilitate clinical reasoning by the therapist in developing intervention planning and implementation that will serve to elicit and enable behavioral change in the adolescents.

Understanding Adolescent

Mental Health

Mental Health

Mental health disorders have been identified as a major contributor to deficits in social functioning among adolescents, and they are positively correlated with delinquent behaviors. Literature suggests that adolescents are frequently placed in the juvenile justice system rather than receiving the appropriate services, due to a lack of resources in communities for diagnosing and treating mental health disorders (Atkins et al. 1999). The following is a description of the psychosocial diagnoses that research suggests are typically observed in adolescent offenders, along with the impact on occupational performance based on the concepts of the MOHO model.

Adolescent Substance Abuse

Description:

It is estimated that over 25% of all adolescents in the U.S. between the ages of 12 to 17 have used an illicit drug. In addition, studies have found that nearly 33% of adolescent boys and 25% of adolescent girls in the U.S. have tried alcohol before the age of 13. The most common substances used by adolescents include alcohol, marijuana, cocaine, LSD, and inhalants. It is said that marijuana is the illicit drug of choice among high school students, and it was the most common drug involved in juvenile arrests in 2000. Of those youth enrolled in substance abuse treatment programs, 97% use alcohol in addition to other substances (Sadock & Sadock, 2004).

Common Diagnoses:

- Substance Intoxication
- Substance Withdrawal
- Substance Abuse
- Substance Dependence

Impact on Occupational Performance:

Volition: disregard for physical danger to one's health and safety; decreased interest in leisure activities; lack of self respect and confidence to do what's right; increased need to "fit in"; skewed perception of values

Habituation: impaired performance in worker / student roles; habitual use resulting in legal problems; routine self-care tasks often neglected; difficulties establishing and adhering to organized schedules and routines; sleeping / eating cycles typically disrupted

Performance Capacity: deficits in social functioning; inability to make good choices; persistent use may inhibit motor and/or cognitive function (loss of balance, uncoordinated movements, poor problem-solving, decreased concentration, distorted thought patterns, non-reality based beliefs; hallucinations or delusions, impaired memory and judgment, etc); impaired communication skills; lack of assertiveness to say no; challenges with seeking assistance from others

Environment: substance use affected by culture and socioeconomic status; experiences of family conflict; drug use influenced by parental behaviors, communication, expectations, and level of supervision or monitoring; inability to cope with societal and/or peer pressures

Anxiety Disorders

Description:

Anxiety disorders are some of the most common mental health conditions worldwide. They frequently accompany other disorders and can affect all age groups from young children to older adults. Persistent anxiety can affect a person physiologically, emotionally, behaviorally and cognitively, typically to the degree that daily function is severely impaired. Those with anxiety disorders exhibit bizarre behaviors and distorted thinking by irrationally perceiving objects or situations as excessively frightening or potentially harmful to them (Cara & MacRae, 2005).

Common Diagnoses:

- Panic Disorder (with or without agoraphobia)
- Specific Phobia / Social Phobia
- Obsessive-Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Generalized Anxiety Disorder
- Substance-Induced Anxiety Disorder

Impact on Occupational Performance:

Volition: participation in leisure interests decreases; ADLs / IADLs become less important; feelings of self-consciousness, poor self-esteem, and loss of control hinder one's self-efficacy; social relationships diminish; increased dependency on others or sense of detachment creates a loss of identity; preference for solitary activities

Habituation: work / education habits and responsibilities decline due to distractibility and persistent worry; typical self-care routines are impaired or completely neglected; worker, student, or parent roles are conflicted; sleep routines are disturbed / interrupted

Performance Capacity: concentration, problem-solving, and attention are impaired; de-conditioning in physical health due to persistent physiological symptoms; presents severe inability to communicate or interact socially with others; increases use of avoidance tactics from fearful situations; physical symptoms may create challenges in fine and gross motor skill (e.g. as with OCD)

Environment: extreme lack of belongingness in the family or societal structure; increased social isolation and depression due to withdrawal from friends, family, and the community; over-exaggerated control over one's personal environment

Attention-Deficit Disorders

Description:

These disorders typically manifest and are diagnosed in childhood, however the symptoms may persist through adolescence and sometimes even into adulthood. Attention-deficit disorders are characterized by patterns of severe inattention, hyperactivity, and impulsivity, which often lead to problematic behaviors, academic challenges, and poor social functioning with peers, teachers, and family. Children or adolescents with attention-deficit disorders frequently have a comorbid diagnosis of depression, obsessive-compulsive disorder, or conduct disorder (Cara & MacRae, 2005).

Common Diagnoses:

- Attention-Deficit Disorder (ADD)
- Attention-Deficit Hyperactivity Disorder

Impact on Occupational Performance:

Volition: play and social interaction are impaired; difficulty engaging quietly in leisure or other activities is present; disregard for classroom rules and respect for others;

Habituation: daily routines are affected by poor organization and distractibility; habitual actions such as shifting motions, jumping up in class, and perseverating on tasks make completion of activities difficult; tasks that require sustained effort are avoided;

Performance Capacity: inability to focus or sustain attention leads to poor learning and deficits in academic performance; excessive fidgeting and extraneous movements interfere with concentration on school work; difficulties in interaction skills (e.g. taking turns, listening when spoken to, responding to conversation appropriately, etc.);

Environment: impairment is evidenced in multiple settings; requires a calm and well controlled environment with minimal distractions; tasks must be structured and parameters clearly identified

Disruptive Behavior Disorders

Description:

Disruptive disorders are typically characterized by patterns of negative, hostile, or defiant behavior that include temperamental outbursts, refusal to obey rules, and combative mannerisms (ODD). Additional behaviors that are observed include infringement upon the rights of others or persistent violation of social rules and age-appropriate norms (Conduct Disorder). These behaviors often involve acts of physical aggression, property destruction, theft, and/or truancy. Disruptive behavior disorder may be diagnosed in either childhood or adolescence, and it is often considered a link to antisocial personality disorder (Cara & MacRae, 2005; Sadock & Sadock, 2004).

Common Diagnoses:

- Oppositional Defiant Disorder (ODD)
- Conduct Disorder

Impact on Occupational Performance:

Volition: no sense of empathy for others; lack of moral value or judgment; interests are socially inappropriate; friendships are limited due to lack of mutual respect; disregard for personal responsibility or consequences

Habituation: often have other negative habits like drug or alcohol use; difficulty adhering to social expectations; vague awareness of one's role in society; maladaptive behaviors result in academic dysfunction and problems with the law

Performance Capacity: deficits in communication / interaction skills; inability to relate to others; difficulty regulating or appropriately expressing emotions; outwardly defies authority; difficulty with solving problems

Environment: those with lower socioeconomic status and who live within urban areas are at higher risk; difficulties abiding by parental prohibitions; unstable conditions in the home; lack of participation within the community; difficulties obtaining or sustaining employment

Eating Disorders

Description:

Eating disorders are marked by severe disturbances in eating behaviors that are characterized by a distorted perception of body image, preoccupation or obsession with weight gain, and a relentless desire to be thin or athletic. These disorders typically manifest during adolescence, and are often contributed to by societal expectations and social pressures from peers and/or family. Behaviors related to these disorders include binging/purging episodes, food restrictions, self-induced vomiting, excessive exercising, or use of other means such as laxatives or diuretics (Sadock & Sadock, 2004).

Common Diagnoses:

- Anorexia Nervosa
- Bulimia Nervosa

Impact on Occupational Performance:

Volition: unrealistic expectations placed on self due to perfectionist characteristics; leisure interests dictated by food; increased need for control over one's life; deficits in self-esteem, self-image, and self-efficacy; sense that personal appearance equals self-worth

Habituation: daily routines affected by obsessions with food and preparation; significant changes in exercise, food intake, and self-care habits; frequently accompanied by negative habits such as alcohol or substance use; decrease in social activities with others, especially those that involve food; strict food routines and eating schedules impair performance in all roles

Performance Capacity: poor communication / interaction skills; frequent isolation from others to hide food obsessions; poor emotional regulation and impulse control; inconsistency in actions (perceived as out-going yet close personal relationships are strained or non-existent); difficulty relating to others; deficits in concentration, problem-solving, and coping ability

Environment: unrealistic perception of societal, peer, and family pressures; stigma associated with an idealistic viewpoint; significant family conflict; structured environments such as school or work create stress due to decreased discretion for binging or purging

Mood Disorders

Description:

Mood disorders, also referred to as affective disorders, are very common conditions that can affect people of all age levels and cultural backgrounds. These disorders are characterized by persistent patterns of depression, mania, or a fluctuation between the two, and are marked by the following symptoms: extreme sadness, decreased interest in daily activities, elevated, expansive, or irritable mood, weight fluctuations, feelings of guilt, hopelessness or worthlessness, and thoughts of death or suicide (Cara & MacRae, 2005).

Common Diagnoses:

- Major Depressive Disorder
- Bipolar Disorder
- Dysthymia (milder form of major depressive episode)
- Cyclothymia (milder form of bipolar disorder)

Impact on Occupational Performance:

Volition: decreased interest in pleasurable activities; negative sense of self-worth and feelings of inadequacy decrease motivation; grandiosity or overinflated self-esteem impairs ability to set realistic goals; difficulty identifying personal values; perceived loss of control over life; employs avoidance tactics; inability to anticipate future success

Habituation: daily ADL routines, such as eating, sleeping, grooming and hygiene, are affected; sleep patterns are disrupted; difficulty following rigorous schedules; challenges with identifying one's roles

Performance Capacity: motor skills are affected through demonstration of psychomotor retardation (slow movements) or psychomotor agitation (anxious and energetic movements); processing skills are impaired (i.e. poor concentration and problem-solving, difficulty making decisions, extreme distractibility, memory, etc.)

Environment: difficulty functioning in larger groups; difficulty with unstructured environments; avoidance of social situations; lack of belongingness within the social structure or community

Personality Disorders

Description:

The DSM IV-TR defined personality disorders as "enduring subjective experiences and behavior that deviate from cultural standards, are rigidly pervasive, have an onset in adolescence or early adulthood, are stable through time, and lead to unhappiness and impairment" (Sadock & Sadock, 2004, p. 336). This set of disorders encompasses a variety of diagnoses that are primarily characterized by impaired social functioning. Personality disorders are most commonly linked to violent, aggressive, and criminal behaviors, which often lead to incarceration (Johnson et al., 2000).

Common PD Diagnoses:

- Paranoid
- Schizoid
- Schizotypal
- Antisocial
- Borderline
- Histrionic
- Narcissistic
- Avoidant
- Dependent
- Obsessive-compulsive
- Passive-aggressive

Impact on Occupational Performance:

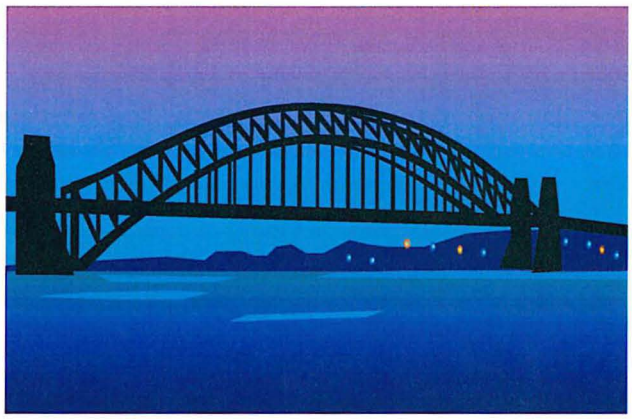
Volition: frequently pursue non-human interests (e.g. animals or academics); social isolation resulting from suspicion or lack of trust in others; social detachment contributes to loss of identity; decreased desire for close personal relationships; lack of value and/or moral judgment; limited interest in social activities; limited vision for future success due to poor self-image and sense of control; need to be taken care of impedes a value for independence; disregard for safety of self and others

Habituation: inability to conform to social norms; routinely violate the rights of others; typically partake in solitary activities; daily routines are highly impaired; habits involve high-risk behaviors such as careless sexual activity or substance/alcohol use; inability to work cooperatively with others leads to impairment in worker / student roles; work history is often inconsistent

Performance Capacity: impaired social competence; limited ability to express emotions appropriately; difficulty initiating and/or sustaining a conversation; lack of assertiveness or overly aggressive; deficits in listening skills; lack of empathy; poor attention span and problem-solving ability; limited coping ability; poor initiation of activity and decision-making

Environment: dysfunctional family relationships; limited access to community involvement and resources; feeling of being controlled by society; disregard for financial obligations and responsibilities; influenced by culture, socioeconomics, and geographical location

Assessments Based on the Model of Human Occupation



Assessments

Building Bridges incorporates assessments developed from concepts of the Model of Human Occupation that are used to evaluate occupational performance. Areas assessed include but are not limited to: social functioning, interests, motivation, participation in activities of daily living, communication and interaction, role identification, self-care, occupational history, and performance skills. The MOHO assessments included in this handbook can be used alone or in conjunction with tools derived from other treatment models in order to obtain a more accurate depiction of the client's level of functioning. When selecting an assessment, therapists need to take several considerations into account. Therapists need to first ensure they have the necessary certification requirements for administering the assessment, since many standardized assessments require special training on administration and scoring to ensure reliability and validity of the measure. The administration methods need to be considered to make sure the client has the appropriate skills needed to complete the assessment, and to verify that all materials necessary for administration are readily available. The time frame needed for administration and scoring is another consideration since schedules vary depending upon the facility, and some individuals may require a more comprehensive approach than others. It is suggested that therapists employ their clinical reasoning skills to determine which assessments most accurately meet the needs of both the therapist and the client. A listing of appropriate assessments for consideration follows:

Model of Human Occupation Screening Tool (MOHOST)

This is a standardized assessment used to determine the need for occupational therapy services and was developed as a screening tool. The format of this assessment is based on observation, discussions, and record review. This assessment is used with clients diagnosed with mental health problems who express difficulty with concentration and concerns. The MOHOST requires days or weeks to complete observation and scoring takes 10-20 minutes. The assessment involves 24 items in the following six categories: motivation for occupation, pattern of occupation, communication and interaction skills, process skills, motor skills, and environment.

Source:

Model of Human Occupation Clearinghouse
University of Illinois at Chicago
Department of Occupational Therapy (MC 811)
College of Applied Health Sciences
1919 West Taylor Street
Chicago, IL. 60612-7250
Tel: 312-413-7469
Fax: 312-413-0256
Website: www.moho.uic.edu

Reference:

Kielhofner, G. (2002). *Model of Human Occupation: Theory and application* (3rd ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Role Checklist

The purpose of this assessment is to assess clients' perceptions of their ability to participate in fulfilling their normal roles. The format consists of a questionnaire and rating form that is self-administered. The Role Checklist can be used with adolescent, adult, or geriatric clients who can read and comprehend the directions of the assessment. The length of time to administer the assessment is 15 minutes. There are 10 roles that are defined that consist of roles and the value of each role.

Source:

Frances Oakley, MS, OTR/L, FAOTA
Occupational Therapy Service
National Institute of Health
Building 10, Room 65-235
10 Center Drive MSC 1604
Bethesda, MD 20992-1604
Email: foakley@nih.gov

References:

Cynkin, S., & Robinson, A. (1990). *Occupational therapy and activities health*. Boston: Little, Brown & Co.

Dickerson, A .E. (1999). The Role Checklist. In B. J. Hemphill-Pearson (Ed.), *Assessment in occupational therapy mental health* (pp. 175-191). Thorofare, NJ: Slack.

Occupational Self Assessment (OSA)

The purpose of the OSA is to collect information on the client's self-perception of occupational competence, occupational functioning, and adaptation of the environment. This assessment is a self-report questionnaire and is administered individually. It is used with clients over age 12, who can complete a self-report independently for 10-20 minutes. The OSA is scored according to a 4-point scale from "I have a lot of problems doing this" to "I do this extremely well."

Source:

Model of Human Occupation Clearinghouse
University of Illinois at Chicago
Department of Occupational Therapy (MC 118)
College of Applied Health Sciences
1919 West Taylor Street
Chicago, IL. 60612-7250
Tel: 312-413-7469
Fax: 312-413-0256
Website: www.moho.uic.edu

References:

Ay-Woan, P., Sarah, C. P., Lyinn, C., Tsyr-Jang, C., & Ping-Chuan, H. (2006). Quality of life in depression: Predictive models. *Quality of Life Research, 15,* 39-48.

Crist, P., Fairman, A., Munoz, J. P., Hansen, A. M. W., Sciulli, J., & Eggers, M. (2005). Education and practice collaborations: A pilot study between a university faculty and county jail practioners. *Occupational Therapy in Health Care, 19, (1/2),* 193-210.

Kielhofner, G. (2002). *Model of Human Occupaiton: Theory and application* (3rd ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Kielhofner, G. & Forsyth, K. (2001). Measurement properties of a client self report for treatment planning and documenting therapy outcomes. *Scandinavian Journal of Occupational Therapy, 8, (3),* 131-139.

Occupational Questionnaire (OQ)

The purpose of this assessment is to gain a better understanding of how the client uses their time throughout daily activities and how it relates to the client's volition. It can be administered using a written self-evaluation or the therapist can interview the client. The OQ can be administered on adults and adolescents. The client will be asked to report how they use their time for every half hour during the day. They list their activities and interests in the activities, followed by how well they complete the activity.

Source:

Model of Human Occupation Clearinghouse
University of Illinois at Chicago
Department of Occupational Therapy (MC 118)
College of Applied Health Sciences
1919 West Taylor Street
Chicago, IL. 60612-7250
Tel: 312-413-7469
Fax: 312-413-0256
Website: www.moho.uic.edu

References:

Smith, N. R., Kielhofner, G., & Watts, J. H. (1986). The relationships between volition, activity pattern, and life satisfaction in the elderly. *American Journal of Occupational Therapy, 40, (4),* 278-283.

Henry, A. D., Costa, C., Ladd, D., Robertson, C., Rollins, J., & Roy, L. (1996). Time use, time management, and academic achievement among occupational therapy students. *WORK: A Journal of Prevention, Assessment and Rehabilitation, 6, (2),* 115-126.

Kielhofner, G. (2002). *Model of Human Occupation: Theory and application* (3rd ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Pentland, W., Harvery, A. S., & Walker, J. (1998). The relationships between time use and health and well-being in men with spinal cord injury. *Journal of Occupational Science, 5, (1),* 14-25.

Occupational Performance History Interview-II (OPHI-II)

The assessment was based on the Model of Human Occupation (MOHO). The OPHI-II is used to gain a better understanding of the client's history and how the diagnoses has impacted his/her life. This assessment consists of three different sections and is administered using a semi-structured interview. This assessment can be used with clients who are able to discuss and respond to interview questions. The time required to administer this assessment is one hour. It consists of five areas regarding occupation and is scored using a 4 point rating scale.

Source:

Model of Human Occupation Clearinghouse
University of Illinois at Chicago
Department of Occupational Therapy (MC 118)
College of Applied Health Sciences
1919 West Taylor Street
Chicago, IL. 60612-7250
Tel: 312-413-7469
Fax: 312-413-0256
Website: www.moho.uic.edu

References:

Kielhofner, G. (2002). *Model of Human Occupation: Theory and application* (3rd ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Kielhofner, G., Mallinson, T., Forsyth, K., & Lai, J.-S. (2001). Psychometric properties of the second version of the Occupational Performance History Interview. *American Journal of Occupational Therapy, 55,* 250-267.

Mallinson, T., Mahaffey, L., & Kielhofner, G. (1998). The Occupational Performance History Interview: Evidence of three underlying constructs of occupational adaptation. *Canadian Journal of Occupational Therapy, 65,* 219-228.

Occupational Circumstances Assessment Interview Rating Scale (OCAIRS)

The OCAIRS provides a structure for obtaining, analyzing, and reporting data about the client's occupational adaptation. This assessment is a semi-structured interview and can be used in an acute inpatient psychiatric facility. The occupational therapist should allot 20-35 minutes to administer the OCAIRS and be familiar with the Model of Human Occupation (MOHO). This assessment consists of 12 areas from MOHO, such as values, interests, past experiences, personal causation, roles, habits, skills, etc. This assessment is scored using a 4 point scale.

Source:

Model of Human Occupation Clearinghouse
University of Illinois at Chicago
Department of Occupational Therapy (MC 118)
College of Applied Health Sciences
1919 West Taylor Street
Chicago, IL. 60612-7250
Tel: 312-413-7469
Fax: 312-413-0256
Website: www.moho.uic.edu

References:

Haglund, L., Thorell, L., & Walinder, J. (1998). Occupational functioning in relation to psychiatric diagnoses: Schizophrenia and mood disorders. *Journal of Psychiatry, 52, (3),* 223-229.

Heasman, D., & Atwal, A. (2004). The Active Advice pilot project: Leisure enhancement and social inclusion for people with severe mental health problems. *British Journal of Occupational Therapy, 67, (11),* 511-514.

Kielhofner, G. (2002). *Model of Human Occupation: Theory and application* (3rd ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Lai, J., Haglund, L., & Kielhofner, G. (1999). Occupational case analysis interview and rating scale. *Scandinavian Journal of Caring Science, 13, (4),* 273-276.

Assessment of Communication and Interaction Skills (ACIS)

The purpose of the ACIS is to gather information regarding the client's interaction skills and communication with the activity. This assessment is structured and requires occupational therapists to obtain the proper training and be certified to administer the assessment. The ACIS can be used with adults, adolescents, and elderly population and the occupational therapist should allow 20-60 minutes to administer. The ACIS measures the following: Physicality, Information exchange, and Relations and consists of two outcomes, goal accomplishment and social impact. The occupational therapist observes the client participate in an activity and then rates the client using a 4 point scale.

Source:

Model of Human Occupation Clearinghouse
University of Illinois at Chicago
Department of Occupational Therapy (MC 118)
College of Applied Health Sciences
1919 West Taylor Street
Chicago, IL. 60612-7250
Tel: 312-413-7469
Fax: 312-413-0256
Website: www.moho.uic.edu

References:

Forsyth, K., Lai, J., & Kielhofner, G. (1999). The Assessment of Communication and Interaction Skills (ACIS): Measurement properties. *British Journal of Occupational Therapy, 62,* 69-74.

National Institutes of Health Activity Record (ACTRE)

The purpose of this assessment is to gain information on how the client spends his/her time and the impact of their diagnoses on daily performance, habits, and interests. It is a questionnaire that requires the client to document three times per day for 48 hours. The ACTRE is used with adolescents with a variety of diagnoses. The occupational therapist asks the client to write down what they are doing every half hour for two consecutive days. The client is asked to report how much energy is used to complete the activity and which category the activity accompanies. The occupational therapist uses a 4 point scale to correctly score the assessment.

Source:

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Department of Health and Human Services
National Institutes of Health
Rehabilitation Medicine Department
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10 Center Drive, MSC 1604
Bethesda, MD 20892-1604
Tel/Fax: 301-402-3012
E-mail: Gfurst@cc.nih.gov

References:

Gerber, L., & Furst, G. (1992). Validation of the NIH activity record: A quantitative measure of life activities. *Arthritis Care Research, 5,* 81-86.

Kielhofner, G. (2002). *Model of Human Occupation: Theory and application* (3rd ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Leidy, N. K., & Knebel, A. R. (1999). Clinical validation of the functional performance inventory in patients with chronic obstructive pulmonary disease. *Respiratory Care, 44, (8),* 932-939.

Packer, T. L., Foster, D. M., & Brouwer, B. (1997). Fatigue and activity patterns of people with chronic fatigue syndrome. *Occupational Therapy Journal of Research, 17, (3),* 186-199.

Strategies For Building Rapport

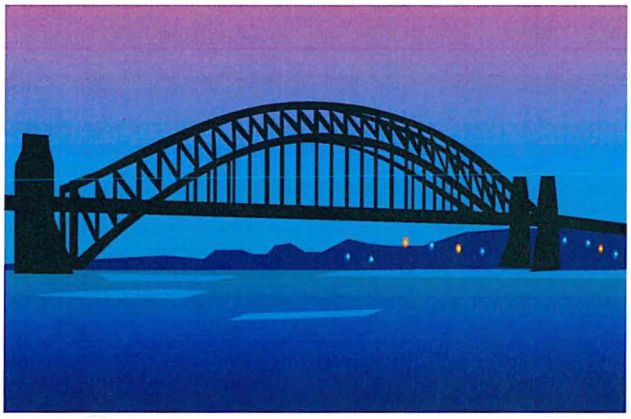
With High-Risk Adolescents

Rapport Building Strategies

In order for treatment intervention to be most effective, Hanna, Hanna, & Keys (1999) suggest the importance of building a strong therapeutic relationship with high-risk adolescents. Developing rapport is especially important for treating adolescents in the juvenile justice system, since they frequently experience conflict with family, peers, and the legal system, which may result in severe mistrust of others. In addition, many of the youth with mental health diagnoses prefer social isolation and detachment, or may simply refuse to participate or disclose personal information to an "authority figure", which ultimately inhibits the treatment process. For this reason, it is important for the therapist to recognize that not all treatment strategies will be effective with each client. Again, the therapist must use clinical reasoning skills to determine which strategies might be most appropriate and beneficial. The following list of rapport-building ideas was adapted from Hanna, Hanna, & Keys (1999), and may assist therapists in developing a stronger therapeutic relationship with delinquent adolescents.

- Be culturally competent
- Create a comfortable and non-threatening environment
- Conduct sessions in a neutral setting
- Be familiar with adolescent interests (music, hobbies, etc.)
- Show respect to the client and the family
- Avoid being a symbol of authority
- Share personally relevant experiences with the client
- Focus on feelings before behaviors
- Avoid power struggles
- Use effective communication (consider nonverbal communication)
- Do not expect adolescents to have the same opinion
- Be clear about boundaries and limits
- Be clear about boundaries and limits
- Avoid outward demonstration of biases
- Validate clients' perceptions
- Recognize transference
- Have patience
- Do not take criticism and negative remarks personally
- Do not expect immediate change
- Recall your own adolescence
- Demonstrate empathy and understanding
- Be able to discriminate between empathy and sympathy
- Show a willingness to learn from the client
- Demonstrate control over your own emotions

Social Wellness Program



Introduction

The following is a program that defines an approach for service delivery for occupational therapists working with adolescents within the juvenile justice system. The program incorporates the MOHO concepts through four phases: 1) needs assessment, 2) program planning, 3) program implementation, and 4) program evaluation (Braveman, Kielhofner, & Belanger, 2008). This program targets social participation as the primary area of concern and includes: identification of the adolescents' problems and challenges, an assessment battery for client evaluation, specific goals and objectives, intervention strategies and group protocols, and evaluation methods necessary for measuring outcomes. The program is meant to serve two purposes: (1) to provide an example of how to apply the MOHO concepts in program development and (2) to offer an actual intervention plan that may be implemented as a supplement to an existing program. The program will strive to improve social participation through self-awareness and self regulation, provide skills necessary for positive interaction, and decrease the frequency of disciplinary write-ups in adolescents. Specific outcomes of the program will depend on each client's individual needs and goals.

Program Development Process

Phase I: Needs Assessment

- Gather information on topic
- Clarify need
- Identify conceptual practice model
- Explain rationale for use of the model

Phase II: Program Planning

- Conceptualize client problems and challenges
- Establish goals
- Develop protocols for assessment and intervention

Phase III: Program Implementation

- Outline specific intervention criteria
- Implement planned protocols
- Documentation

Phase IV: Program Evaluation

- Review and analyze goals
- Measure outcomes
- Re-evaluate effectiveness of program

Needs Assessment

This social wellness program was developed based on information obtained in a comprehensive literature review revealing a need for implementing social intervention strategies for the rehabilitation of delinquent adolescents. Research expressed the importance of social interaction throughout the developmental process and the factors that contribute to social dysfunction in adolescents, such as social difficulties with peer and family relationships interconnected with negative emotions and behaviors (Santrock, 2003). Persistent social and behavioral problems are commonly linked to mental health concerns, but because communities may lack access and/or funding resources, many adolescents tend to go undiagnosed and untreated, resulting in placement in the juvenile justice system. Literature suggests that rehabilitative services are needed using a multidisciplinary approach that includes occupational therapy services. Since occupational therapy values social participation as a necessary and key component for healthy functioning (AOTA, 2002), a need to incorporate occupational therapy treatment strategies designed to address negative social issues in adolescents who experience emotional and behavioral problems is present.

MOHO was selected due to the extensive research that has been conducted on the use of this model for assessing and treating adolescents with mental health concerns and delinquency (Scholle-Martin, 1987; Lederer, Kielhofner, & Watts, 1985; Oakley, Kielhofner, & Barris, 1985; Barris et al., 1986). According to Munoz, Lawlor, & Kielhofner (1993), therapists in mental health who have used this model have expressed

that MOHO most closely matches the occupation based philosophy of OT through a holistic, comprehensive, and organized approach.

Program Plan

The foundational principles of MOHO are centered around the idea that "human beings having an innate desire to explore and master their environment by engaging in occupational behavior" (Sholle-Martin, 1987, p. 4) Concepts of this model were used to conceptualize problems and challenges in relation to volition (personal causation, values, and interests), habituation (habits, roles, and routines) and performance capacity (personal experience and skill), in addition to the impact of the physical and social environment in which occupation occurs. These problems were used to establish goals for therapy, and aided in the development of assessment and intervention protocols that target those goals.

Problems/challenges/goals

MOHO Component	Problems/Challenges of Adolescents	Occupational Therapy Goals
Volition (Interests, values, personal causation)	• Social isolation • Increased value for autonomy • Value leisure over responsibility • Decrease in motivation • Feelings of failure • Difficulty identifying values • Intentionally disregard consequences of negative behavior • Difficulties with feelings of belonging	• Promote healthy relationship building skills • Increase social participation through group activity • Increase confidence and self-esteem • Help to identify interests • Encourage responsibility for actions • Encourage self-expression • Promote coping skills

MOHO Component	Problems/Challenges of Adolescents	Occupational Therapy Goals
Habituation (roles, habits, and routines)	• Difficulties interpreting roles between child and adult • Decrease in ADL's • Difficulty creating consistent routines • Negative habits for coping abilities • Displaced emotions	• Increase tolerance of others • Develop social roles • Provide choices throughout treatment • Promote opportunities for community involvement • Help to establish individual identity

MOHO Component	Problems/Challenges of Adolescents	Occupational Therapy Goals
Performance capacity and skills	• Deficits in attention, memory, and problem solving • Deficits in communication • Lack of appropriate interaction skills	• Increase communication and interaction skills • Increase cognitive skills/abilities

MOHO Component	Problems/Challenges of Adolescents	Occupational Therapy Goals
Environment/contexts	• Difficulty due to lack of structure in the home • Negative behaviors as a result of peer influence • Stigma and prejudice associated with mental illness • Limited community access	• Educate on the availability of community supports/services • Educate family members/caregivers on positive environmental aspects • Help individual identify barriers to participation • Provide opportunities for social participation

OT Group Protocol

Intervention for the social wellness program will primarily involve group activities guided by an occupational therapist and an occupational therapist assistant to facilitate social interaction among peers. Individual sessions may be scheduled if necessary. The intervention topics addressed will include:

- expressive interaction
- communication skills
- social skills
- team building
- leisure

The goal of the group is to provide a positive and healthy social environment, along with opportunities to learn and practice components needed for social competence. The group will last a total of 14 weeks, allowing two weeks to complete initial evaluations, 10 weeks for implementation of interventions, and two weeks for outcome measures and re-evaluation. Groups will be conducted twice a day, three days per week for one hour each session, and will consist of no more than six members in each group. Group participants will be referred by physicians, occupational therapists, vocational rehabilitation, social workers, case managers, and counselors. A maximum of 12 people can be referred for the program. Those referred after the initial two week evaluation period will not be allowed to attend the session and will have to wait until the next 14 week session begins, unless other accommodations have been made. Throughout the program, participants will complete a self assessment biweekly to identify progress and anticipated goals. Outcomes

will be measured and participants re-evaluated during the last two weeks of the program. Some participants may be required to attend the 14 week program a second time if necessary.

Group Protocol Outline

NAME OF GROUP: Occupational Therapy Social Wellness Group

DESCRIPTION: Social participation is a vital aspect of adolescent development. Interaction is encompassed in all areas of occupation including ADLs / IADLs, play, education, work, and leisure, therefore, impairment in social functioning can be detrimental to the youth's emotional, physical, and cognitive growth. In addition, social dysfunction inhibits the ability to adapt in one's environment, resulting in poor learning capacity, negative behaviors, emotional distress, and potential legal problems. The goal of this group is to evaluate socially-related skills and to provide opportunities for education and practice in an environment that is non-threatening and conducive to social performance. Aspects of focus will include self-awareness and expression, communication, social skill, team building, and leisure.

GOALS:

1. Provide a non-threatening environment that will encourage motivation to participate.
2. Promote social interaction through group-oriented activities.

ENTRANCE CRITERIA:

1. Group members will be referred by physicians, social workers, case managers, counselors, vocational rehab, and other professionals.
2. No more than six members in each group.
3. Members must be emotionally stable and of no threat to themselves or others.

GROUP RULES:

1. Actively participate
2. Provide feedback
3. Respect others' boundaries, property, and opinion
4. Share
5. Have fun

FORMAT: Groups will be directed by an occupational therapist and an assistant. Group will meet twice per day, three times per week, for one hour each session.

EXIT CRITERIA: Members exit the program once completed, or discharged from the facility. Some participants may be required to complete the program a second time if necessary.

Assessment Protocol

Assessments are used for occupational therapists to obtain information about the clients' occupational history, client factors, performance skills, and contexts that affect occupational performance. Within this social wellness program, clients will undergo initial evaluation within the first two weeks of referral. The method for evaluation includes a chart review, interviews, observation, and three assessments based on the MOHO model: the Occupational Circumstances Assessment Interview Rating Scale (OCAIRS), the Assessment of Communication and Interaction Skills (ACIS), and the Occupational Self Assessment (OSA). These assessments were selected due to their content and effectiveness in obtaining a holistic overview of the clients, specifically their values, roles, habits, skills, interests, and environmental factors. Throughout the program, group members will complete self evaluations bi-weekly to monitor progress and areas of concern. During the last two weeks of the program session, outcome measures and re-evaluations will be conducted, using MOHO assessments and other methods such as interviews, skilled observations, and survey questionnaires. An outline of the assessment protocol is provided.

Assessment Protocol Outline

NAME OF GROUP: Occupational Therapy Social Wellness Group

INITIAL EVALUATIONS: conducted with each client during the first two weeks of the group

1. Chart Review
2. Initial Interview
3. Observation
4. OCAIRS
5. ACIS
6. OSA

PROGRESS REPORTS: Completed biweekly by each group member.

1. Self Evaluation

RE-EVALUATIONS / OUTCOMES: conducted during the last two weeks of group

1. Interviews with client, case workers, teachers, and family
2. Survey questionnaires
3. OSA
4. Review of disciplinary records

Program Implementation

Interventions will be implemented through co-treatment by an occupational therapist and an occupational therapist assistant. Groups will involve five major topics, which include: (1) expressive interaction, (2) communication skills, (3) social skills, (4) team building, and (5) leisure. Each intervention topic will be addressed for a two-week period and will include activities that have been specifically tailored to address those topics. Protocols for each intervention topic have been developed to offer information about the subject and guidelines for implementation. Following the protocols, an activities outline is provided, which lists specific intervention ideas that may be used. Documentation will be completed on all group members at the conclusion of each group session, following specific guidelines identified per facility.

Intervention Protocols

GROUP TOPIC: Expressive Interaction

DESCRIPTION: Self expression is an important skill in the developmental process for adolescents, and it provides youth with a sense of identity, a means for coping, and a method for interaction with others. This is an introductory group topic that uses games, collages, and various activities to facilitate self-awareness and self-expression, and also to allow members to meet one another and get familiarized with occupational therapy and the group process.

PURPOSE: The purpose of this group is to begin establishing rapport and developing the adolescents' self-esteem and confidence within a social environment. The group involves interventions that allow members a non-threatening way to communicate with others, and that encourage the adolescents to begin sharing information and initiating interaction.

GOALS:

1. Develop rapport
2. Increase participation among group members
3. Enhance self-awareness
4. Increase self-esteem and confidence
5. Values recognition

MODALITY: The therapist will include parallel group activities, group discussions, and use of various methods of art media to enhance self expression with group members. Positive feedback will be provided, along with encouragement for participation and self disclosure.

GROUP TOPIC: Communication Skills Development

DESCRIPTION: Good communication skills help build the foundation for healthy social functioning because they are a vital and necessary aspect of basic interaction between the adolescent and the environment. Since adolescents often have a difficult time expressing themselves and relating to others, learning to employ effective communication skills can improve confidence and self-esteem needed to enhance performance in all areas of the adolescents' lives. The interventions for this group will facilitate positive communication skills through use of hands-on activities and constructive feedback from therapist and peers.

PURPOSE: To increase self-esteem and confidence in social situations by enhancing the adolescents' knowledge and skills needed to effectively communicate with others in a variety of contexts.

GOALS:

1. Promote self-esteem and confidence
2. Increase awareness of verbal and non-verbal interaction
3. Develop assertiveness skills
4. Develop good listening skills
5. Learn to give and receive positive feedback

MODALITY: Interventions will include educational activities and discussions, along with opportunities to practice communication skills through role play, games, and real-world experiences.

GROUP TOPIC: Social Skills Development

DESCRIPTION: Social skills are an important component to adolescents' development. Adolescents build their social identity through social interaction with peers and family members, including: expressing feelings, emotions, interpersonal skills, and communication skills.

PURPOSE: The purpose of this group is to educate on the necessary social skills that assist adolescents in developing more positive interactions and relationships. Interventions will include areas such as, problem solving, anger management, interpersonal skills, coping skills, self-regulation, and conflict resolution.

GOALS:

1. Provide a positive and healthy environment
2. Encourage participation through group activities
3. Improve appropriate interaction skills
4. Practice scenarios for a variety of context

MODALITY: The occupational therapist will assist adolescents with positive social interaction through the use of games, role playing, and group activities. Scenarios will be used to enhance problem based learning and decision making skills, along with feedback from the therapist.

GROUP TOPIC: Team Building

DESCRIPTION: Learning to work collaboratively with others is an important component for developing social and relational skills. Team building can assist youth in learning to develop and fulfill certain roles within a team oriented environment, which may help increase leadership skills that are beneficial in school and future employment.

PURPOSE: The purpose of this intervention is to create a team work scenario that promotes cooperation and support among members, increases problem solving skills, and encourages trust and leadership that is necessary to reach a common outcome.

GOALS:

1. Increase relational skills
2. Provide activities that encourage problem solving skills
3. Enhance individual/team strengths
4. Identify responsibilities and expectations related to roles

MODALITY: The occupational therapist will provide physical activities that will challenge members to create a common goal and use teamwork to reach a successful outcome.

GROUP TOPIC: Leisure Group

DESCRIPTION: Leisure is an important aspect of occupational performance in adolescents because they frequently place high value on leisure, often to where it occupies a greater amount of their time than other roles, such as student, worker, and family member. Leisure can serve many purposes including: recreation, coping and stress management, social interaction and feelings of accomplishment in completing a task.

PURPOSE: The purpose of this group is to facilitate awareness of the value of leisure, enhance social interaction, and increase leisure interests and participation among adolescents.

GOALS:

1. Introduce and increase adolescents' interests in positive leisure activities
2. Enhance leisure activities in a variety of community settings
3. Improve healthy interaction between group members, peers, and family members

MODALITY: The occupational therapist will educate on the importance of leisure, provide activities that encompass their existing interests, and provide additional options for further leisure participation.

Intervention Outlines

Expressive Interaction Unit
VALUE RECOGNITION / SELF- AWARENESS

Purpose:
To increase awareness of personal values and willingness to share them with others

Group Objective:
To recognize and respect the differences in personal values, and to explain how they influence thoughts and behaviors.

Items Needed:

Butcher Paper / Poster Board/ or Construction Paper
Various Magazines
Glue
Scissors
Markers

Activity / Group Discussion:

1) Explain to the group that they will be making a collage with pictures that represent them and their personal values/interests.
2) Provide needed materials and explain that they must share.
3) If some finish sooner than others, have individuals write on the collage, something they would like to change or accomplish in relation to those values/interests.
4) After completion of the collages, ask each member to discuss their collage with the group, and explain how their interests guide their decisions and behaviors.
5) Clean up

Conclusion / Processing:

1) Discuss how personal values are established.
2) Encourage comparison of similarities and differences among members' values and interests
3) Discuss whether or not values can change, and ways in which this happens.

Expressive Interaction Unit
GROUP INTRODUCTIONS

Purpose:
To provide a method for introducing oneself to other group members in a non-threatening manner

Group Objective:
Members will become familiar with the group context and will begin interacting with others by introducing oneself and participating in a social activity without feelings of threat or embarrassment.

Items Needed:

List of non-threatening, open-ended introductory questions

- What is your favorite color?
- Name a game you like to play.
- What is your favorite television show?

Beach ball

Activity / Group Discussion:

1) Group should start with a warm-up activity. Start by having each member introduce themselves to the group. Have the group form a circle and toss a beach ball to one another as they repeat that person's name. Play until all members become familiar with one another.
2) Cut out above introductory questions, fold, and place in a container. Pass the container around the room and have each member draw a question, then read and answer it verbally to the group. Continue passing the container until all questions have been answered.

Conclusion / Processing:
Conclude group by having participants recite members' names again and try to recall something significant that was shared by one or two other members.

Other suggestions:
Develop a game in which participants must guess things about the person sitting next to them. Make sure the statements/questions are neutral and non-threatening. Some example questions might include: What state do you think the person grew up in; Do you think the person prefers city life or country life; What do you think is that person's favorite food, etc. Each person guesses answers to the same questions about the person to his/her left, and writes them down on a sheet of paper. After all questions are completed, group members compare the guessed answers with the actual answer from the person. This activity is a good way to begin interaction among group members.

Expressive Interaction Unit
JOURNAL

Purpose: To create a journal or folder that the adolescent may use as a tool for expressing oneself and gauging social progress; the journal or folder may also be used to hold papers or notes from the group sessions that the adolescent wants to save for future reference.

Group Objective: To increase self-awareness and provide a non-threatening means for expressing one's thought, feelings, and emotions; the journal may serve as a coping mechanism in reducing anxiety for those who are uncomfortable with being in a social setting.

Items Needed:

Cardboard	glue
Writing paper / construction paper	scissors
Hole punch	Yarn, ribbon, leather strapping, spiral binding, etc.

Decorating materials (magazine pictures, art supplies, fabrics, CD covers, etc)

Activity / Discussion:

1) What is a journal? What is it used for?
2) Activity will begin with a discussion of what journaling is and how it can be a useful tool for coping and recognizing one's thoughts and feelings. It may be used for expressing angry emotions so they are not projected socially on others, or it may be helpful in alleviating stress, anxiety, or sadness by reducing suppression of negative feelings.
3) After discussion, individuals will be supplied with materials for making his/her own journal or folder. It may be helpful to have a completed example for the adolescents to look at.

Conclusion / Processing:

- What sort of things can be written in a journal? (pictures, drawings, ideas, goals, etc)
- In what ways do you see this helping with your social interactions?
- Do you think this could be a helpful tool? Why or why not?
- When might you see yourself using this?

Expressive Interaction Unit
EXPRESSIVE ART / DRAWING

Purpose: To draw a picture of one's family or peer network, including self, using only plants, animals, or objects to represent the people. The drawing can include only one set (i.e. only animals or plants, but not both).

Group Objective: To allow the adolescent and therapist to explore the youths' social perceptions of others, and identify those people within their social structure that are perceived as supportive and those who are social barriers. This will also help the adolescent recognize his/her place within the social structure.

Items Needed:

Butcher paper / poster board
Colored pencils, markers, paint, pastels, chalk, etc

Activity / Discussion:

1) Explain that the individuals will be drawing their family or network of friends, including themselves, using only pictures of animals, plants, or objects to represent them.
2) When finished, discuss each person's drawing, including why he/she chose the theme that they did, how the structure is organized, and how he/she fits into that structure (e.g. is the individual very large or small in size compared to other figures).
3) Identify if the drawing truly represents the social structure in real life (for example, if Mom is drawn as the largest object on the page, is she the family authority in real life?)

Conclusion / Processing:

- What reason did you have for selecting the theme that you did?
- Do you think this picture is accurate?
- Who do you consider supportive, and who is a barrier to your social participation?
- What did you think of this activity? What did you gain from doing this?

Communication Skill Development Unit
ASSERTIVE COMMUNICATION

Purpose:
To learn assertiveness that will increase confidence and self-esteem necessary for effective communication with others

Group Objective:
Members will be able to differentiate between communications styles and apply the use of assertiveness skills to different situations.

Items Needed:

Information on communication styles
Butcher block paper
Markers
Assertiveness worksheets
Scenarios

Activity / Group Discussion:

1) Discuss different communication styles (passive, aggressive, passive-aggressive, and assertive) and create a list of behaviors for each one.
2) Have each member identify his/her communication style.
3) Offer scenarios and allow members to practice responding assertively to those scenarios.

Conclusion / Processing:
The conclusion consists of group members sharing how they responded to the scenarios. Provide homework where members have to practice using assertiveness at least one time out of group and be prepared to share next group session.

Communication Skill Development Unit
ACTIVE LISTENING

Purpose:
The purpose of this group is to enhance listening skills to improve verbal interaction.

Group Objective:
Members will learn the behaviors necessary for being an active listener in order to enhance communication.

Items Needed:

White board
Markers
Handouts-stories
Paper
Pencils

Activity/Discussion:

1) Activity would begin with a discussion on what active listening is and why it is important in our communication. Have group members brainstorm the concepts of active listening and take turns writing them on the board.
2) Divide group members into pairs and give each group a story. Have one member of the group read the story, while the other person actively listens. Once the story is finished, the listener will complete a fill-in-the-blank worksheet to determine how well they listen to certain details. Then, partners will switch places.

Conclusion/Processing:
Have group members discuss the results from their worksheets and summarize the activity. Reiterate why active listening is important.

Communication Unit
DEVELOPING CONVERSATION SKILLS

Purpose: To increase communication by improving conversation skills with other people, especially when first meeting them.

Group Objective: To improve self-esteem in communicating with others and to enhance social interaction among group members. Group members will have an opportunity to use conversational strategies for a variety of situations.

Items Needed:

White board or butcher paper
Marker
Index cards with social scenarios on them

Activity / Discussion:

1) First discuss the importance of effective conversation skills (making first impressions, building relationships, etc) and why people often feel awkward with this (nervousness, low self-esteem, lack of positive experiences, etc).
2) Next, have the group brainstorm skills that are needed for effective conversation:
    - Face and look directly at the person you are talking/listening to
    - Avoid talking too much about yourself
    - Stay focused on the person and actively listen to the person's response
    - Use neutral topics or topics of mutual interest (weather, recent movies, current events, community activities)
    - Be in tune to your non-verbal expressions and gestures (smile, look interested)
    - Be honest, but do not overdo it
    - Be genuine and give sincere compliments / feedback
    - Accept compliments by saying Thank You
    - Avoid touchy or controversial subjects like religion, politics, or overly personal information
    - End the conversation pleasantly by saying "Nice meeting you", "It's been nice talking to you", etc.
    - Provide each member with a social scenario and have the adolescent role play the conversations for practice using the above skills

Conclusion / Processing:

- Ask group members which specific skills they think they need to work on?
- Ask members what kind of behaviors they like to see and don't like to see when first meeting someone. Make a list of these on the board.
- Engage the group in a discussion with the following questions:
  1) When do we overuse "I" statements?
  2) What is a good physical distance between people?
  3) What does active listening mean?
  4) How do we show others that we are actively listening to them?
  5) What is considered too honest in a first meeting?
  6) What would be inappropriate information to share at a first encounter?
  7) What are some common non-verbal gestures to recognize in a conversation?
- Discuss with group members some of the potential places or situations where they could work on these skills.

Communication Unit
NON-VERBAL COMMUNICATION

Purpose: To recognize non-verbal communication as an important aspect of effective interaction

Group Objective: Group members will learn to identify and interpret others' body language, non-verbal gestures, and emotional expression

Items Needed:

Index cards with different emotions written on them
Pictures of people cut from magazines
Charades type game

Activity / Discussion:

1) Discuss with members why it is important to be able to communicate non-verbally and recognize what others might be feeling by their expressions and/or behaviors
2) Have members discuss what non-verbal behaviors they are most in tune to when interacting with others
3) Provide index cards with pictures of different emotions on them, and have group members identify and interpret what they think the person is feeling and why they made that choice
4) Play emotion charades – have each group member take turns acting out emotions that other members can guess OR play a typical charades game where members must act out scenarios using body language only
5) Have group members observe others within the facility and try to recognize non-verbal behaviors that are most obvious and some of those which they wouldn't normally notice

Conclusion / Processing:

- Why is it important to understand non-verbal communication?
- How can being in tune to non-verbal communication improve social interaction?
- What type of non-verbal interaction would you prefer to be around? Which would you prefer to avoid?
- Can you think of any non-verbal behaviors that you demonstrate that might affect your interaction with others (or portray a message that could be misinterpreted)?
- What is the best way to avoid misinterpretation of one's behaviors or emotions?

Social Skill Development Unit
ANGER MANAGEMENT

Purpose:
To provide more positive methods for managing anger

Group Objective:
Members will identify their anger style and develop means for dealing with anger issues that are more positive rather than negative.

Items Needed:
Paper
Pencils

Activity/Discussion:

1) Discuss the benefits of managing anger in comparison to escalating or suppressing anger and identify methods for successfully managing the anger.

   Methods
   - The Empty Chair: Pretend you are sitting across from the person you are angry with and say what is on your mind.
   - Writing a Letter: Write a letter to the person you are angry with, describing your anger at the time the incident happened, right now, or both.
   - Relaxation Techniques: Use methods such as, music, progressive muscle relaxation, deep breathing, or meditation.
   - Constructive vs. Destructive Actions: Try selecting activities such as, physical outlets that include exercise, housework, crafts, etc., or develop action plans such as, doing something good for the community.

2) Have each member list two scenarios of anger provoking situations, place them on separate sheets of paper, and place them in a container. Divide the group into pairs and have each group draw two scenarios and discuss a positive technique for dealing with that particular situation.

Conclusion/Processing:
Have the members identify which methods were beneficial and why, or share other techniques with the group. Have group discuss the effects of poor anger management and positive anger management coping strategies.

Social Skill Development Unit
PROBLEM SOLVING-DECISION MAKING

Purpose:
To increase decision-making skills by learning how to "weigh things out."

Group Objective:
It is easy for adolescents to become overwhelmed while making decisions, especially if peers are pressuring them and adolescents may experience internal conflict while making the decision. Members will learn and practice how to "weigh" the pros and cons of decisions.

Items Needed:
White Board
Markers
Handouts

Activity/Discussion:

1) Have members take turns writing two decisions they have made in the past six months on the whiteboard. Each member will then verbally explain to the other members why they chose that decision and the pros and cons of each. Have members describe strategies that could be used in the future when dealing with decision making.
2) Have the group brainstorm more pros and cons for each decision listed on the board. Take turns describing which decision other group members would have made and why. Discuss the repercussions if negative decisions were made and the rewards if positive decisions were made. Provide feedback as needed.

Conclusion/Processing:
Summarize the importance of using the "weighing" method. Have group members describe the benefits of using this particular method.

Social Skill Development Unit
MANNERS

Purpose:
To increase socialization by educating the adolescent group members about appropriate manners in a variety of environments.

Group Objective:
Members will learn and practice appropriate manners in daily life to increase social skills with others.

Items Needed:

Construction Paper
Markers
Case Scenarios
Chairs (for role playing)

Activity/Discussion:

1) Members will be divided into pairs. Each pair of members will identify positive and negative manners in three different case scenarios. Have members list both positive and negative manners they possess on the construction paper.
2) Have the group members discuss all positive and negative manners in the scenarios as a class and verbally explain which manners they could improve. Provide feedback as needed.
3) Each group of two will role play one of the scenarios in front of all group members. Then hold a discussion regarding manners in different environments (i.e. school, home, community).

Conclusion/Processing:
Summarize the importance of using positive rather than negative manners in a variety of settings. Have group members explain how they may use positive manners instead of negative manners in these different settings.

Social Skill Development Unit
CONFLICT RESOLUTION

Purpose:
To decrease aggression by teaching skills necessary for dealing with confrontation and resolving conflict

Group Objective:
Members will learn and practice appropriate methods for resolving conflict and dealing with negative social interactions with others.

Items Needed:
Butcher Paper
Pens
Scenarios

Activity/Discussion:

4) Members will identify two conflicts they have experienced in the past two weeks and explain how they dealt with them. Have members describe strategies that could be used in the future when dealing with confrontation.
5) Have the group analyze conflict scenarios and have them describe the choices they would make to resolve the conflict. Focus the activity on using feelings and assertiveness rather than blame and aggression. Provide feedback as needed.

Conclusion/Processing:
Summarize the importance of using positive rather than negative ways to deal with conflict. Have members explain how they may use positive methods in their own interactions.

Team Building Unit
ROPES COURSE

Purpose:
To promote cooperation and teamwork among group members

Group Objective:
Members will learn the importance of roles and teamwork in order to work collaboratively to achieve a common goal.

Items Needed:
Stationary or mobile ROPES course

Activity/Discussion:

1) Discuss with members the importance of using a ROPES course to develop team work and leadership strengths. Make sure that proper training, rules and expectations, and safety awareness is emphasized.
2) Members will partake in physical activities based on a particular ROPES course program.

Conclusion/Processing:
Summarize the importance of being part of a team and what qualities are needed to be a good team member.

Team Building Unit
CREATE OWN ACTIVITY

Purpose:
To provide adolescent group members the opportunity to explore and create their own team building activity while using communication, collaboration, creativity, and planning.

Group Objective:
Members will increase communication, collaboration, creativity, and planning to reach a common goal.

Items Needed:
Paper
Pencils

Activity/Discussion:

1) Discuss the importance of being a positive team member and what characteristics are important (i.e. active listening, communication, respect, etc.).
2) Divide group into two teams. Have each team create a group activity to share in front of all group members. Allow 20-30 minutes to complete the activity. Provide input and feedback if needed, along with ideas (i.e. singing, dancing, role playing, etc.).
3) When activities are completed, have each group perform their activity. Discuss what aspects of the activity the group members enjoyed while being part of a team.

Conclusion/Processing:
Have members discuss what characteristics they used to be successful in planning an activity. Discuss why it is important to be a team member and different situations when you may find yourself as part of a team (i.e. school, work, etc.).

Team Building Unit
ROLE DELINEATION

Purpose:
To teach the importance of using individuals' strengths working collaboratively to achieve a common goal

Group Objective:
Members will identify their current roles and personal strengths that can contribute to the common good of the team.

Items Needed:
Container
Paper
Pens
Scissors

Activity/Discussion:

4) Discuss what roles are and responsibilities associated with different roles. Discuss how expectations shape behavior choices.
5) Write a variety of roles on slips of paper and place them in a container. Have each member draw one slip from the container and read the role aloud, followed by a discussion of the responsibilities within that role. Have the individual explain what he/she does well within that role and what he/she does not do well. Discuss how these roles contribute to the functioning of a team.

Conclusion/Processing:
Discuss the need for having satisfaction within one's roles and how this pertains to teamwork.

Team Building Unit
TEAM MURAL AND COMMUNITY SERVICE PROJECT

Purpose: To allow the adolescents to create a team mural that may be donated to a community facility such as a nursing home, senior center, homeless shelter, children's hospital, etc. Additional volunteer projects may be used in conjunction with the mural project to facilitate social involvement within the community.

Group Objective: To increase a sense of accomplishment in working together as a team and to instill a sense of pride and connectedness to other within the community. This activity will also promote and facilitate awareness of broader social opportunities.

Items Needed:

Large portable canvas (and a means for hanging it)
Paints, brushes, tarps, aprons (or painting clothes), plastic, stirring sticks
Additional materials that may be used for painting (squish balls, rags, etc)
Large area that is well-ventilated and can be easily cleaned

Activity / Discussion:

1) This activity will take place over several sessions. It should begin with a discussion of the project and expectations that everyone must be involved. Adolescents can begin by brainstorming a community facility of interest that they may want to donate the painting to and/or volunteer their time in.
2) The mural will be a team project that requires effort from all members. It is important to explain that members must work together, and that the project does not necessarily require that one be a good artist. It only requires creativity and team spirit.
3) While the project is in process, the therapist may make arrangements within the community (or have some of the group members assist with this) for volunteer time and for hanging the artwork at the facility. This effort should be well coordinated with the facility's administration along with permission from all necessary sources.

Conclusion / Processing:

- What did you enjoy most about doing this project?
- What, if any connections did you feel while working in the community?
- Do you think you would like to volunteer more often for those who are vulnerable?
- How would this benefit you and others?

Leisure Unit
LEISURE EXPLORATION

Purpose:
To promote the use of leisure for coping and stress reduction

Group Objective:
Members will learn the benefits of leisure and identify leisure activities they may want to explore further.

Items Needed:

Paper
Pencils
Puzzle
Board game
Paint
Paint brushes
CD player
Relaxation CD
Necessary food items

Activity/Discussion:

1) Discuss the purpose and benefits of leisure. Have the members describe leisure activities that they enjoy participating in and why.
2) Leisure stations-Leader will provide six stations that encompass different leisure activities that are easily affordable and require minimal materials. Each station should be explained and each member will be allotted five minutes per station. Some options are listed below but others may be used if desired.
    A) Put a puzzle together
    B) Draw or paint a picture
    C) Listen to music
    D) Plan a dream vacation
    E) Write a letter to a friend
    F) Make a snack

Conclusion/Processing:
Have members discuss which leisure activity they enjoyed the most and why. Reiterate the importance of leisure and which activities they would like to pursue further.

Leisure Unit
INDOOR GARDENING

Purpose:
To provide an opportunity for adolescents to experience the leisure activity of gardening indoors.

Group Objective:
Members will participate in an indoor gardening leisure activity while demonstrating positive social interaction skills.

Items Needed:

Soil
Flowers
Water
Flower Pots
Saucers

Activity/Discussion:

1) Discuss what materials are needed and the appropriate steps to planting flowers.
2) Ask the following questions:
    A) Where can you get flowers?
    B) What are some different types of flowers?
    C) Where could you have flowers in your home?
    D) What do flowers need to live?
3) Have each member chose type and color of flower to plant. Pass out materials to each group member and allow them an allotted amount of time to plant his/her flowers.
4) After completion of activity, have group members discuss why they chose that type of flower.

Conclusion/Processing:
Summarize the importance of positive leisure activities and other creative ideas that could be explored (i.e. decorating pots, arranging flowers in a vase, and outdoor gardening).

Leisure Unit
LEISURE SCAVENGER HUNT

Purpose:
To identify positive ways to use "free-time" and increase interest in leisure activities.

Group Objective:
Members will identify positive leisure activities they may want to explore in the community.

Items Needed:
Pencils
Handouts
Phone Books

Activity/Discussion:

1) Discuss positive leisure activities in the community. Have the members divide into groups of three. Each group will be provided with a worksheet with the following categories: movie theatres, museums, parks, recreation classes, book/music/video stores, theme parks, hobby stores, and special interests. Each group will have to locate names and phone numbers of where it is possible to participate in the different activities.
2) Have group members use decision-making skills to determine the activities for special interests. After each group has completed the worksheet, have group members discuss their results. and which activities they would be interested in participating in.

Conclusion/Processing:
Have members discuss which leisure activities they may be interested in and which activities they would not be interested in, while also having them explain why or why not.

Leisure Unit
BOWLING

Purpose:
To provide an opportunity to use leisure skills within the community that enhances social interaction and teamwork

Group Objective:
Members will participate in a leisure activity while demonstrating social etiquette and positive social interaction skills.

Items Needed:
Permission
Money for bowling

Activity/Discussion:

5) Discuss group expectations prior to leaving the facility, which include: full participation, appropriate behaviors, respect for others within the facility, and being socially active.

Conclusion/Processing:
Discuss usefulness of this leisure activity
Was this a good stress reliever?

Program Evaluation

The goal of the social wellness program is to improve social participation through self-awareness and self-regulation, increase skill development necessary for positive interaction, and decrease the frequency of disciplinary write-ups for adolescents within the juvenile justice system. Assessments used to measure the adolescents' outcomes include: a post program re-evaluation using the Occupational Self Assessment (OSA); survey questionnaires to identify aspects of the program the adolescents found useful; interviews with the client, teachers, case managers, and family members to determine if social functioning has improved in other contexts; and review of disciplinary records to identify any changes in the number and type of outbursts and whether or not they were able to demonstrate use of the learned skills to modulate their behaviors.

References

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CHAPTER V

SUMMARY

The purpose of this scholarly project was to address the social difficulties with peer and family relationships interconnected with negative emotions and behaviors that are frequently experienced by adolescents. Persistent social and behavioral problems can often result in severe impairment and eventual involvement in the juvenile justice system. A variety of disciplines address negative social issues as an area of concern, however, occupational therapy services are frequently underutilized. Since occupational therapy values the importance of social participation as a necessary and key component for healthy functioning (AOTA, 2002), there is an increased need to integrate occupational therapy services within the rehabilitative approach, with treatment strategies designed to address social issues among adolescents who experience emotional and behavioral problems.

A comprehensive literature review was conducted to obtain information regarding the adolescent population and interventions that may be used to assist in their rehabilitation. The research revealed that adolescents often do not receive the services needed due to limited resources in many communities.

Based on these findings, the Building Bridges handbook was developed to be used by occupational therapists that are employed in a mental health setting, for addressing social performance in adolescents. The handbook is meant to serve as a

resource guide for intervention planning and implementation, and includes assessments that may be used with the adolescent population, rapport building strategies, and information on a variety of common diagnoses. This handbook assists the therapists in developing critical thinking skills, and aid in decision making and therapeutic use of self while working with at-risk adolescents. The goal of this handbook is to: (1) increase awareness of the social concerns in juvenile delinquency; (2) enhance the knowledge and confidence of occupational therapists working with troubled adolescents; (3) provide information that is user-friendly and easily accessible; and (4) strengthen the occupational therapy profession by using evidence-based literature to guide practice.

The Social Wellness Group is a program within Building Bridges for occupational therapists working in mental health facilities with adolescents. This sample program targets social participation as the primary area of concern and includes: identification of the adolescents' problems and challenges, an assessment battery for client evaluation, specific goals and objectives, intervention strategies and group protocols, and evaluation methods necessary for measuring outcomes. The program is meant to serve two purposes: (1) to provide an example of how to apply the MOHO concepts in program development and (2) to offer an actual intervention plan that may be implemented as a supplement to an existing program. The program strives to improve social participation through self-awareness and self regulation, provide skills necessary for positive interaction, and ultimately decrease the frequency of disciplinary incident reports in adolescent treatment settings. The Social Wellness Group includes the following intervention categories: expressive interaction, communication skills, social skills, team building, and leisure exploration. The group lasts a total of 14 weeks, allowing two weeks to complete initial

evaluations, 10 weeks for implementation of interventions, and two weeks for outcome measures and re-evaluation. Groups are conducted twice a day, three days per week for one hour each session, and consist of no more than six members in each group.

Limitations and Recommendations

The handbook is limited to addressing needs of youth living in community treatment centers. While potential for application in higher-security settings is likely good, it was not written with this population in mind. Use in these settings will require further study of the professional literature and revision of the handbook. Another limitation of the handbook is that it is targeted for adolescents. In order for occupational therapists to use this handbook with other age groups, it would require altering the assessments for a specific age group while also altering the interventions to meet the needs of the group members. A final limitation is the materials generated are not research-tested; therefore, occupational therapists considering this program may need to collect research data to determine the effectiveness of the Social Wellness Program.

Another limitation is the decreased number of occupational therapists working in mental health facilities. Many facilities lack the funding to employ occupational therapists, so cross-training among professionals is prevalent. Therefore, treatment is provided by those who are less experienced with psychosocial interventions. Finally, in order to implement this project into mental health facilities, in-services would need to be provided, not only to occupational therapists, but all professionals at each facility. It is important for other professions to understand and acknowledge the importance of occupational therapy interventions to meet the needs of each client.

Building Bridges and the Social Wellness Program provides occupational therapists with assessments, sample interventions, and guidelines to assist them in their work with adolescents in the juvenile justice system. The Social Wellness Program provides therapists with specific social participation interventions that can be beneficial to both the adolescent and the family members, while focusing on social skills necessary for youth.

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